Pharmacy

# Prior Authorization Criteria for Nasal Allergy Drugs

**Background**

The nasal allergy drugs include fluticasone propionate (Flonase), ipratropium (Atrovent), flunisolide (Nasarel), and azelastine 137 mcg (Astelin), mometasone (Nasonex), fluticasone furoate (Veramyst), azelastine 205 mcg (Astepro), budesonide (Rhinocort Aqua), beclomethasone (QNASL), ciclesonide 50 mcg (Omnaris), olopatadine (Patanase), ciclesonide 37 mcg (Zetonna), beclomethasone (Beconase AQ), and fluticasone/azelastine (Dymista). These drugs are used in the treatment of allergic and non-allergic rhinitis.

**What is Step Therapy?**

Step therapy involves prescribing a safe, cost effective medication as the first step in treating a medical condition. The preferred medication is often a generic mediation that offers the best overall value in terms of safety, effectiveness, and cost. Non-preferred drugs are only prescribed if the generic is ineffective or poorly tolerated. **Astepro, Beconase AQ, QNASL, Rhinocort Aqua, Zetonna, Omnaris, Veramyst, Dymista, Nasonex, and Patanase** will only be approved for current and new users who are older than 4 years of age after they have satisfied the requirements to try the preferred agents on the Department of Defense (DoD) Uniform Formulary AND the clinical requirements listed below.

**Prior Authorization Criteria for Nasal Allergy Drugs**

PA criteria apply to all new and current users of Astepro, Beconase AQ, QNASL, Rhinocort Aqua, Zetonna, Omnaris, Veramyst, Dymista, Nasonex, and Patanase who are older than 4 years of age.

**Automated PA criteria**: The patient has filled a prescription for azelastine 137 mcg, flunisolide, fluticasone propionate, or ipratropium at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days.

AND

**Manual PA criteria**: Astepro, Beconase AQ, QNASL, Rhinocort Aqua, Zetonna, Omnaris, Veramyst, Dymista, Nasonex, or Patanase is approved (e.g., trial of azelastine 137 mcg, flunisolide, fluticasone propionate, or ipratropium is NOT required) if:

- Patient has experienced any of the following issues with **at least one** of the following step-preferred Nasal Allergy Drugs (fluticasone propionate, flunisolide, azelastine, or ipratropium), which is not expected to occur with the non-preferred Nasal Allergy drug:
  - inadequate response to the step-preferred drugs
  - intolerable adverse effects (persistent epistaxis, significant nasal irritation, pharyngitis)
  - contraindication
  - no formulary alternative for the following
    - for budesonide (Rhinocort Aqua): patient is pregnant (pregnancy category B)
    - for beclomethasone (Beconase AQ) and mometasone (Nasonex): patient has nasal polyps and cannot be treated with one of the step-preferred products

*Criteria approved through the DOD P&T Committee process May 2014*

Falls Church, VA 22042

TRICARE Prior Authorization Request Form for

# Nasal Allergy Drugs

6057

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

| | |
|---|---|
| MAIL ORDER and RETAIL | • The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477**<br><br>• The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: **TPharmPA@express-scripts.com** |

***Note: Prior authorization criteria applies for patients who are older than 4 years.***

## Step 1

**Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

## Step 2

**Please complete the clinical assessment:**

| | | |
|---|---|---|
| **1. Which medication is requested?** | ☐ **Beconase AQ** (beclomethasone) – **Proceed to question 2**<br>☐ **Nasonex** (mometasone) – **Proceed to question 2**<br>☐ **Rhinocort Aqua** (budesonide) – **Proceed to question 3**<br>☐ **All others** – **Proceed to question 4** | |
| **2.** *(Beconase AQ / beclomethasone or Nasonex / mometasone request)* **Does the patient have nasal polyps and cannot be treated with azelastine 137 mcg nasal spray** (Astelin)**, flunisolide nasal spray, fluticasone propionate nasal spray** (Flonase)**, or ipratropium nasal spray** (Atrovent nasal spray)**?** | ☐ Yes<br>Sign and date below | ☐ No<br>**SKIP** to question **4** |
| **3.** *(Rhinocort Aqua / budesonide request)* **Is the patient a female who is pregnant?** | ☐ Yes<br>Sign and date below | ☐ No<br>Proceed to question 4 |
| **4. Has the patient tried azelastine 137 mcg nasal spray** (Astelin)**, flunisolide nasal spray, fluticasone propionate nasal spray** (Flonase)**, or ipratropium nasal spray** (Atrovent nasal spray) **and experienced an inadequate response or an intolerable adverse effect** (for example, persistent nose bleed, significant nasal irritation, or sore throat)**?** | ☐ Yes<br>Sign and date below | ☐ No<br>Proceed to question 5 |
| **5. Does the patient have a contraindication to ALL of the following: azelastine 137 mcg nasal spray** (Astelin)**, flunisolide nasal spray, fluticasone propionate nasal spray** (Flonase)**, and ipratropium nasal spray** (Atrovent nasal spray)**?** | ☐ Yes<br>Sign and date below | ☐ No<br>Coverage not approved |

## Step 3

**I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[17 December 2014]